



**WORKGROUP ON ACCESS TO
HABILITATIVE SERVICES BENEFITS**

INTERIM REPORT

MSAR #9128

NOVEMBER 2012

WORKGROUP ON ACCESS TO HABILITATIVE SERVICES BENEFITS

Membership Roster

Maryland State Senate Member
Co-Chair
The Honorable Senator Richard S. Madaleno, Jr.
District 18, Montgomery County

Maryland House of Delegates Member
Co-Chair
The Honorable Ariana B. Kelly
District 16, Montgomery County

Maryland Insurance Commissioner
Therese M. Goldsmith

Representative of the Maryland Health Care Commission
Bruce Kozlowski

Representative of the Maryland State Department of Education
Steven D. Sorin

Representative of the Maryland Developmental Disabilities Council
Rachel London

Representative of the Maryland Department of Disabilities
Rachael Faulkner

Representative of the Department of Health and Mental Hygiene
Debbie Badawi, M.D.

Physical Therapist
Ginny Paleg

Occupational Therapist
Lori Tolen

Speech-Language Pathologist
Kimberly A. Bell

Pediatricians
Robert L. Blake, M.D.
Abila Tazanu-Legall, M.D.

K-12 Educator
Nancy FitzGerald

Early Intervention Educator
Thomas J. Stengel

A Parent of a Child with Special Needs
Kelli Nelson

Representatives of Insurers
Joe Winn, Aetna
Deborah R. Rivkin, CareFirst BlueCross BlueShield
Brenda Myrick, Coventry Health Care of Delaware
Joseph A. Vander Walde, M.D., Kaiser Permanente
Edward P. Koza, M.D., United HealthCare

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Introduction

During the 2012 session, the Maryland General Assembly passed Senate Bill 744/ House Bill 1055 (Chapters 293/294)¹, which require, among other things, that the Maryland Insurance Commissioner (Commissioner) establish a workgroup on access to habilitative services benefits and report to the Senate Finance Committee and House Health and Government Operations Committee on its findings and recommendations. This document constitutes the interim report that is due November 1, 2012. A final report is due November 1, 2013.

Chapters 293/294 require the workgroup to determine: (1) whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them; (2) if the children are not receiving the habilitative services, the reasons why; (3) any actions needed to promote optimum use of the habilitative services to maximize outcomes for children and reduce long-term costs to the education and health care systems; and (4) the costs and benefits associated with expanding habilitative services coverage to individuals under the age of 26 years.

Habilitative Services Mandated Benefit

The Maryland habilitative services mandated benefit was enacted by Chapter 92 of the Acts of 2000 and was codified as § 15-835 of the Insurance Article, Annotated Code of Maryland. The mandate applies to insurers, nonprofit health service plans, and health maintenance organizations (carriers). It requires carriers to provide coverage for habilitative services for a child under the age of 19. The term “habilitative services” is defined in the law to mean “services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child’s ability to function.” Chapter 92 of the Acts of 2000 also required a carrier to provide an annual notice about habilitative services coverage to its insureds and enrollees.

Since 2000, two bills have been passed that amended the Maryland habilitative services mandate. The first amendments were made in 2002² and accomplished the following:

- A definition of the term “congenital or genetic birth defect” was added to the law. The new definition specifically included autism, autism spectrum disorder and cerebral palsy.
- The amendments provided that denial of a request or payment for habilitative services on the grounds that a condition or disease was not a congenital or genetic birth defect is an adverse decision and subject to appeal to the Maryland Insurance Administration.

Chapters 293/294 provided the second amendment to the habilitative services mandate since 2000. They clarified that the definition of congenital or genetic birth defect includes intellectual disability, Down syndrome, spina bifida, hydroencephalocele and congenital or

¹ Copies of the chapter laws appear in Appendix 1.

² Chapter 382, Acts of 2002.

genetic developmental disabilities, as well as autism, autism spectrum disorder, and cerebral palsy. The annual notice requirement regarding the habilitative services mandate also was amended to require the notice to be provided to insureds and enrollees in print and on the carrier's website. Chapters 293/294 also required the Commissioner to establish a workgroup on access to habilitative services benefits and the Department of Health and Mental Hygiene (DHMH), in consultation with the Commissioner, to establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

Workgroup on Access to Habilitative Services Benefits

The Commissioner convened a workgroup on access to habilitative services benefits consisting of a physical therapist, an occupational therapist, a speech-language pathologist, pediatricians, K-12 and early intervention educators, a parent of a child with special needs, and representatives of insurers, the Maryland Insurance Administration (MIA), the Maryland Health Care Commission, the Maryland State Department of Education (MSDE), the Maryland Developmental Disabilities Council, the Maryland Department of Disabilities, and the Department of Health and Mental Hygiene. Senator Madaleno, appointed by the President of the Senate, and Delegate Kelly, appointed by the Speaker of the House, serve as co-chairs of the workgroup.

The health care provider and educator members of the workgroup were recruited from state agencies or professional associations and the parent member was recommended by MIA staff. The insurers selected to be included in the workgroup were chosen based on market share and health benefit plan offerings in the State.

Between June 2012 and October 2012 the workgroup met five times at the offices of the MIA and began the work of examining the issues encompassed in its charge.³

At the first and second meetings of the workgroup, some preliminary observations expressed by the members were: (1) there are some potential barriers to accessing the benefits under the habilitative services mandate; and (2) there is a need for coordination between health care providers and the education system in the provision of habilitative services.

Potential Barriers to Access

The workgroup's discussions included many comments from the health care provider members regarding how parents are unsure of or uninformed about their rights to accessing habilitative services benefits under their health benefit plans. Parents need guidance understanding the availability of habilitative services outside of the education forum. Health

³ Minutes for the June 27, 2012, August 21, 2012, September 5, 2012, and September 19, 2012, meetings appear in Appendix 2. As of this interim report's publication date, the October 3, 2012 meeting minutes have not been approved.

care providers also may be uninformed about the availability of habilitative services benefits under health benefit plans.

Based on these discussions, the workgroup plans to develop two documents. The first document will provide guidance to parents when contacting their carriers to access habilitative services benefits. The document will be available on the websites of the MIA, DHMH, the Maryland Developmental Disabilities Council and the Maryland Department of Disabilities. The second document is a guide for parents of a child with special needs describing habilitative services, how coverage for habilitative services benefits could differ between plans subject to the mandate and plans not subject to the mandate, and the services provided through the health care system and those provided under a child's educational plan. The document also will provide links to websites with more information.

Coordination of Services Between Health and Education Systems

MSDE serves as the State's lead agency for administration of the statewide early intervention system. Early intervention services are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family to assist appropriately in the infant's or toddler's development. Through the early intervention services provided by the Infants and Toddlers Program, a family is given an Individualized Family Services Plan (IFSP) that identifies the family concerns, priorities and resources, determines goals and provides a written plan for achieving the goals. At least once every six months, the IFSP is reviewed by a team, including a parent, to determine if progress is being made and if outcomes or services need to be modified.

Eligibility for preschool special education services is determined for a child already within the Infants and Toddlers Program when the child reaches the age of 33 months. If eligible, the child may continue to receive services through an IFSP until age 4 or the child may transition to preschool special education services and an Individualized Educational Program (IEP) is developed. Through an IEP, special education and related services are provided by the education system. Special education means specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability. Starting at age 14, MSDE begins providing assistance for when the child is outside of the school system - either college bound or living independently.

Workgroup members observed that health care providers who are providing habilitative services independent from the education system generally do not consult with the education system regarding habilitative services provided within the education system, and there is a lack of care coordination between the two systems.

MIA Data Regarding PT, OT, and ST Complaints

For calendar year 2011, the MIA received a total of 86 complaints involving claims for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services. Sixty-one of those 86 complaints were handled by the Life/Health complaint unit, which means that they did

not involve denials based on medical necessity.⁴ Twenty-five of the 86 complaints were handled by the Appeals and Grievance unit. Of the 25 cases, only six involved children. Five of the six were for rehabilitative services only. In one of those five cases, the complainant wanted the services to be paid as habilitative, but the independent review organization ruled that the services were rehabilitative.

More Information Needed

In order to more fully identify the potential barriers to accessing habilitative services benefits and to make the determinations with which it is charged, the workgroup concluded that it needs to gather more information from four different perspectives – carriers, the education system, health care providers, and parents. In particular, the workgroup agreed that this additional information would assist the workgroup in determining (1) whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them; and (2) if the children are not receiving habilitative services, the reasons why. The workgroup divided into four subgroups to develop methodologies to gather information from the identified populations.

Subgroup One: Carriers

The carriers in the subgroup have committed to provide the workgroup with data for calendar years 2010 and 2011 regarding: the number of claims/requests for services, the number of claims paid/approvals, and the number of claims denied/pre-authorizations denied for children with diagnosis codes commonly associated with habilitative services. These data runs are intended to help the workgroup determine if one barrier to accessing habilitative services benefits relates to carrier denials of payment for those services. Separate data runs will be made for the Maryland insured market and for the Maryland self-funded market for which the carriers provide administrative services. While the self-funded market is not subject to the Maryland mandate, the carriers in the subgroup pointed out that some self-funded plans voluntarily provide a habilitative services benefit. The data run for the self-funded market will help the workgroup decide if there is a greater lack of access to habilitative services benefits in the employer self-funded market. The data will be broken down by the following age groups: birth to less than 3 years of age; 3 years of age to less than 6 years of age; 6 years of age to less than 11 years of age; and 11 years of age to 18 years of age. Once the carriers provide the information to the workgroup, the workgroup will determine what, if any, further information is needed from carriers.

⁴ Nine of the 61 complaints that were handled by the Life/Health complaint unit were from one provider and dealt with delays by a carrier.

Subgroup Two: Providers

The provider subgroup is developing two surveys for health care providers. One survey will be directed to primary care practitioners; the other will be directed to allied health professionals. The purposes of the surveys are to determine: (1) whether respondents are referring children with special needs for additional services; (2) the criteria respondents are using for the referrals; (3) the programs or services to which respondents are making referrals; (4) whether respondents understand when the State's habilitative services mandate applies (e.g., fully insured vs. self-funded plans); (5) the source(s) of respondents' referrals; (6) provider experience with carriers in processing claims; and (7) any barriers to respondents in referring children for habilitative services.

Subgroup Three: Parents

The parent subgroup is developing a survey for parents to determine whether habilitative services are being provided through a health plan or an educational plan or both. The survey will also gather information about any delay in obtaining habilitative services and on the perceived availability of services in different geographical areas of the State. The survey also is intended to obtain data, though anecdotal, regarding the experiences that parents are having when accessing or attempting to access habilitative services benefits under their health benefit plans.

Subgroup Four: Educators

The educators subgroup plans to gather and assess data on where referrals to the early intervention programs are originating. In addition, the subgroup is conducting a review of the individual county Infants and Toddlers Program websites to determine the accessibility and navigability of the websites.

Next Steps

The workgroup has made significant progress in beginning the research needed to respond to the Maryland General Assembly's request for findings and recommendations. At this time, it is too early to provide the results of the research or any specific recommendations.

The workgroup is next scheduled to meet on December 19, 2012.

APPENDIX 1

Chapter 293

(Senate Bill 744)

AN ACT concerning

Health Insurance – Habilitative Services – Required Coverage and, Workgroup, and Technical Advisory Group

FOR the purpose of ~~altering the age under which certain insurers, nonprofit health service plans, and health maintenance organizations must provide coverage of habilitative services;~~ specifying the format in which certain insurers, nonprofit health service plans, and health maintenance organizations must provide a certain notice about the coverage must be provided of habilitative services; requiring that certain determinations made by certain insurers, nonprofit health service plans, and health maintenance organizations be made in accordance with certain regulations beginning on a certain date; requiring the Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner, to establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders; establishing the composition of the technical advisory group; requiring the technical advisory group to develop certain recommendations and obtain certain input; requiring the Commissioner, on or before a certain date, to adopt certain regulations based on the recommendations of the technical advisory group; requiring the Maryland Insurance Commissioner to establish a workgroup on access to habilitative services benefits; specifying the composition of the workgroup; requiring the workgroup to make certain determinations; requiring the Commissioner to report submit certain reports on the findings and recommendations of the workgroup, on or before a certain date certain dates, to certain legislative committees; altering a certain definition; providing for the construction of this Act; and generally relating to health insurance coverage of habilitative services.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–835
Annotated Code of Maryland
(2011 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–835.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) “Congenital or genetic birth defect” means a defect existing at or from birth, including a hereditary defect.

(ii) “Congenital or genetic birth defect” includes, but is not limited to:

1. autism or an autism spectrum disorder; [and]

2. cerebral palsy;

3. **INTELLECTUAL DISABILITY;**

4. **DOWN SYNDROME;**

5. **SPINA BIFIDA; AND**

6. **HYDROENCEPHALOCELE; AND**

7. **CONGENITAL OR GENETIC DEVELOPMENTAL DISABILITIES.**

(3) “Habilitative services” means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child’s ability to function.

(4) “Managed care system” means a method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section shall provide coverage of habilitative services for children under the age of ~~19~~ ~~21~~ years and may do so through a managed care system.

(2) An entity subject to this section is not required to provide reimbursement for habilitative services delivered through early intervention or school services.

(d) An entity subject to this section shall provide notice annually to its insureds and enrollees about the coverage required under this section:

(1) IN PRINT; AND

(2) ON ITS WEB SITE.

(e) A determination by an entity subject to this section denying a request for habilitative services or denying payment for habilitative services on the grounds that a condition or disease is not a congenital or genetic birth defect is considered an "adverse decision" under § 15-10A-01 of this title.

(F) BEGINNING NOVEMBER 1, 2013, A DETERMINATION BY AN ENTITY SUBJECT TO THIS SECTION OF WHETHER HABILITATIVE SERVICES COVERED UNDER THIS SECTION ARE MEDICALLY NECESSARY AND APPROPRIATE TO TREAT AUTISM AND AUTISM SPECTRUM DISORDERS SHALL BE MADE IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner, shall establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

(b) The technical advisory group shall be composed of individuals with expertise in the treatment of children with autism and autism spectrum disorders.

(c) The technical advisory group shall develop recommendations for the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

(d) When making a recommendation, the technical advisory group shall consider whether the recommendation is:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; and

(4) flexible enough to allow deviations from norms when justified on a case by case basis.

(e) In its work, the technical advisory group shall obtain input from the public, including input from:

(1) parents of children with autism and autism spectrum disorders;
and

(2) the insurers, nonprofit health service plans, and health maintenance organizations that are subject to § 15-835 of the Insurance Article, as enacted by Section 1 of this Act.

(f) Based on the recommendations of the technical advisory group, the Commissioner, on or before November 1, 2013, shall adopt regulations that relate to the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders for purposes of § 15-835 of the Insurance Article, as enacted by Section 1 of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Insurance Commissioner shall establish a workgroup on access to habilitative services benefits.

(b) The workgroup shall consist of :

(1) one member of the Senate of Maryland, appointed by the President of the Senate;

(2) one member of the House of Delegates, appointed by the Speaker of the House; and

(3) physical therapists, occupational therapists, speech pathologists, pediatricians, K-12 and early intervention educators, a parent of a ~~special-needs~~ child with special needs, and representatives of insurers, the Maryland Insurance Administration, the Maryland Health Care Commission, the Maryland State Department of Education, the Maryland Developmental Disabilities Council, the Maryland Department of Disabilities, and the Department of Health and Mental Hygiene.

(c) The workgroup shall determine:

(1) whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them;

(2) if the children are not receiving the habilitative services, the reasons why; ~~and~~

(3) any actions needed to promote optimum use of the habilitative services to:

(i) maximize outcomes for children; and

(ii) reduce long-term costs to the education and health care systems; and

(4) the costs and benefits associated with expanding habilitative services coverage to individuals under the age of 26 years.

(d) (1) On or before November 1, 2012, the Commissioner shall submit an interim report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on the findings and recommendations of the workgroup.

(2) On or before November 1, 2013, the Commissioner shall submit a final report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on the findings and recommendations of the workgroup.

SECTION 4. AND BE IT FURTHER ENACTED, That the changes made under Section 1 of this Act to the definition of "congenital or genetic birth defect" in § 15-835(a)(2) of the Insurance Article are intended to clarify the scope of coverage of services required under § 15-835 as it existed before the effective date of this Act, and are not intended, and may not be interpreted or construed, to expand the coverage of services required under § 15-835 as it existed before the effective date of this Act.

SECTION ~~3~~ 5. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2012.

Approved by the Governor, May 2, 2012.

Chapter 294

(House Bill 1055)

AN ACT concerning

Health Insurance – Habilitative Services – Required Coverage ~~and~~, Workgroup, and Technical Advisory Group

FOR the purpose of ~~altering the age under which certain insurers, nonprofit health service plans, and health maintenance organizations must provide coverage of habilitative services;~~ specifying the format in which certain insurers, nonprofit health service plans, and health maintenance organizations must provide a certain notice about the coverage ~~must be provided~~ of habilitative services; requiring that certain determinations made by certain insurers, nonprofit health service plans, and health maintenance organizations be made in accordance with certain regulations beginning on a certain date; requiring the Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner, to establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders; establishing the composition of the technical advisory group; requiring the technical advisory group to develop certain recommendations and obtain certain input; requiring the Commissioner, on or before a certain date, to adopt certain regulations based on the recommendations of the technical advisory group; requiring the ~~Maryland Insurance~~ Commissioner to establish a workgroup on access to habilitative services benefits; specifying the composition of the workgroup; requiring the workgroup to make certain determinations; requiring the Commissioner to ~~report~~ submit certain reports on the findings and recommendations of the workgroup, on or before a ~~certain date~~ certain dates, to certain legislative committees; altering a certain definition; providing for the construction of this Act; and generally relating to health insurance coverage of habilitative services.

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(ii) “Congenital or genetic birth defect” includes, but is not limited to:

1. autism or an autism spectrum disorder; [and]
2. cerebral palsy;
3. **INTELLECTUAL DISABILITY;**
4. **DOWN SYNDROME;**
5. **SPINA BIFIDA;**
6. **HYDROENCEPHALOCELE; AND**
7. ~~DEVELOPMENTAL DISORDERS (LEARNING, READING, MATHEMATICS, SPEECH, AND SPELLING)~~ **CONGENITAL OR GENETIC DEVELOPMENTAL DISABILITIES.**

(3) “Habilitative services” means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child’s ability to function.

(4) “Managed care system” means a method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section shall provide coverage of habilitative services for children under the age of ~~19~~ ~~21~~ years and may do so through a managed care system.

(2) An entity subject to this section is not required to provide reimbursement for habilitative services delivered through early intervention or school services.

(d) An entity subject to this section shall provide notice annually to its insureds and enrollees about the coverage required under this section:

(1) IN PRINT; AND

(2) ON ITS WEB SITE.

(e) A determination by an entity subject to this section denying a request for habilitative services or denying payment for habilitative services on the grounds that a condition or disease is not a congenital or genetic birth defect is considered an "adverse decision" under § 15-10A-01 of this title.

(F) BEGINNING NOVEMBER 1, 2013, A DETERMINATION BY AN ENTITY SUBJECT TO THIS SECTION OF WHETHER HABILITATIVE SERVICES COVERED UNDER THIS SECTION ARE MEDICALLY NECESSARY AND APPROPRIATE TO TREAT AUTISM AND AUTISM SPECTRUM DISORDERS SHALL BE MADE IN ACCORDANCE WITH REGULATIONS ADOPTED BY THE COMMISSIONER.

SECTION 2. AND BE IT FURTHER ENACTED, That:

(a) The Department of Health and Mental Hygiene, in consultation with the Maryland Insurance Commissioner, shall establish a technical advisory group on the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

(b) The technical advisory group shall be composed of individuals with expertise in the treatment of children with autism and autism spectrum disorders.

(c) The technical advisory group shall develop recommendations for the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders.

(d) When making a recommendation, the technical advisory group shall consider whether the recommendation is:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; and

(4) flexible enough to allow deviations from norms when justified on a case by case basis.

(e) In its work, the technical advisory group shall obtain input from the public, including input from:

(1) parents of children with autism and autism spectrum disorders;
and

(2) the insurers, nonprofit health service plans, and health maintenance organizations that are subject to § 15-835 of the Insurance Article, as enacted by Section 1 of this Act.

(f) Based on the recommendations of the technical advisory group, the Commissioner, on or before November 1, 2013, shall adopt regulations that relate to the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders for purposes of § 15-835 of the Insurance Article, as enacted by Section 1 of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Insurance Commissioner shall establish a workgroup on access to habilitative services benefits.

(b) The workgroup shall consist of:

(1) one member of the Senate of Maryland, appointed by the President of the Senate;

(2) one member of the House of Delegates, appointed by the Speaker of the House; and

(3) physical therapists, occupational therapists, speech pathologists, pediatricians, K-12 and early intervention educators, a parent of a ~~special-needs~~ child with special needs, and representatives of insurers, the Maryland Insurance Administration, the Maryland Health Care Commission, the Maryland State Department of Education, the Maryland Developmental Disabilities Council, the Maryland Department of Disabilities, and the Department of Health and Mental Hygiene.

(c) The workgroup shall determine:

(1) whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them;

(2) if the children are not receiving the habilitative services, the reasons why; ~~and~~

(3) any actions needed to promote optimum use of the habilitative services to:

(i) maximize outcomes for children; and

(ii) reduce long-term costs to the education and health care systems; and

(4) the costs and benefits associated with expanding habilitative services coverage to individuals under the age of 26 years.

(d) (1) On or before November 1, 2012, the Commissioner shall submit an interim report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on the findings and recommendations of the workgroup.

(2) On or before November 1, 2013, the Commissioner shall submit a final report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on the findings and recommendations of the workgroup.

SECTION 4. AND BE IT FURTHER ENACTED, That the changes made under Section 1 of this Act to the definition of "congenital or genetic birth defect" in § 15-835(a)(2) of the Insurance Article are intended to clarify the scope of coverage of services required under § 15-835 as it existed before the effective date of this Act, and are not intended, and may not be interpreted or construed, to expand the coverage of services required under § 15-835 as it existed before the effective date of this Act.

SECTION ~~4~~ 5. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2012.

Approved by the Governor, May 2, 2012.

APPENDIX 2

Workgroup on Access to Habilitative Services Benefits

Meeting Minutes

Meeting Date: June 27, 2012

Call to Order: The first meeting of the Workgroup on Access to Habilitative Services Benefits was held in the 24th Floor Hearing Room of the Maryland Insurance Administration, Baltimore, Maryland, on June 27, 2012. Commissioner Goldsmith called the meeting to order at 9:00 a.m.

Members in Attendance:

Debbie Badawi, MD	Bruce Kozlowski
Kimberly A. Bell	Brenda L. Myrick
Robert A. L. Blake, M.D.	Kelli P. Nelson
Rachael Faulkner	Deborah Rivkin
Nancy FitzGerald	Steven D. Sorin
Therese M. Goldsmith	Abila Tazanu-Legall, M.D.
Delegate Ariana B. Kelly (Co-Chair)	Lori Tolen
Edward P. Koza, M.D.	Joseph Vander Walde, M.D.

Workgroup Members Not in Attendance:

Rachel London	Thomas J. Stengel
Senator Richard S. Madaleno, Jr. (Co-Chair)	Joe Winn
Ginny Paleg	

Workgroup Staff in Attendance:

Nancy Egan
Tinna Quigley
Brenda Wilson

Others in Attendance:

Robert Axelrod	Linda Stahr
Carol Itter	Pam Tenemaza
Kimberly Robinson	

Welcome Remarks: Commissioner Goldsmith thanked the Workgroup for their participation and asked the Workgroup members to introduce themselves. Commissioner Goldsmith introduced Delegate Arianna Kelly, the co-chair of the Workgroup.

Delegate Kelly thanked the Workgroup for their participation and provided the background for Chapters 293/294 (Acts of 2012). She stated that Senator Madaleno had been working for several sessions on the issue of expanding coverage for habilitative services beyond the current age of 19. Delegate Kelly became involved with this issue two years ago and has concentrated her efforts on access to habilitative services.

Discussion of Future Meeting Dates: Commissioner Goldsmith reviewed possible meeting dates with the group. The dates provided conformed to the legislative calendar and availability

of the hearing room at the Maryland Insurance Administration (MIA). Commissioner Goldsmith asked that anyone with suggestions for an alternative meeting location e-mail MIA staff. After polling the members present, it was decided that at least three meetings should be held prior to October and one additional meeting in October, if needed. It was suggested that a survey be sent out using Survey Monkey to poll the group about future meeting dates.

Workgroup Charges: Commissioner Goldsmith described potential subworkgroups to address the Workgroups charges:

Determine:

1. whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them;
2. if the children are not receiving habilitative services, the reasons why;
3. any actions needed to promote optimum use of habilitative services to:
 - (a) maximize outcomes for children; and
 - (b) reduce long-term costs to education and health care systems; and
4. the costs and benefits associated with expanding habilitative services coverage to individuals under the age of 26 years.

She then opened the floor for discussion on the issue. Most members indicated that they would be interested in participating in the Workgroup's charges across multiple potential subworkgroups. It was decided that instead of subworkgroups, the Workgroup would work in stages to study charges 1 and 2 followed by charges 4 and 3, respectively.

Discussion of Charges 1 and 2: Commissioner Goldsmith asked for each member to provide their initial thoughts on Workgroup charges 1 and 2:

Coverage for Habilitative Services

Several insurance company representatives stated that they provide coverage for pre-authorized physical therapy (PT), occupational therapy, (OT) and speech-language pathology (SLP) services as mandated under current law. Rehabilitative services are limited in coverage. There is confusion for the consumer between rehabilitative and habilitative services. Parents need to ask for a specific person and to know key words when calling their insurance company to determine coverages. Providers also seem unaware of what to ask for when seeking prior authorization.

Delegate Kelly noted that Maryland law defines habilitative services as services *including* OT, PT and SLP (*emphasis added*). The law does not limit benefits to those services. Delegate Kelly stated that there is another technical advisory group created under Chapters 293/294 on the medically necessary and appropriate use of habilitative services to treat autism and autism

spectrum disorders. She agrees that a parent does not know the key words to use when inquiring about coverage for habilitative services. Many parents choose to go outside of their network and those providers do not know the plan coverages for out-of-network benefits.

Health Plans Vary So Coverage Varies

Insurance company representatives pointed out that consumers are confused about their health plans. If a health plan is not a fully insured product it may not provide all the mandated benefits required under Maryland law. Many consumers in Maryland have a self-insured plan or a federal employee health benefit plan. Insurance companies explain the coverages but it is important to look at the portals where children enter the system – educational system, pediatrician, physical therapist, speech-language pathologist, etc. Only approximately 25% of Marylanders have insurance under fully insured plans. The MIA regulates approximately 36% of employer-provided plans.

One therapist Workgroup member stated that she often has patients covered under health plans that are not required to provide the mandated benefits under Maryland law. Many parents become frustrated with their insurance companies and give up.

Another therapist member stated that insurance coverage will change during a child's life as a parent may change health plans or change employers. In addition, coverage levels change and network providers change. The therapist stated that most OTs, PTs, and SLPs who are skilled in the needs of children with autism spectrum disorders are out-of-network. In-network providers may not be the best providers and can have long waiting lists.

Delegate Kelly stated that the Affordable Care Act (ACA) may change some of this for parents. While the ACA does not cover self-funded plans for 2014 it will give parents the option of opting-out of their employer's plan and purchasing an individual plan in the Exchange.

Consumer Education Needed

One of the members stated that: (1) parents have a lack of information or misinformation about their rights to access; (2) some pediatricians think that referring parents to the Infants and Toddlers program is enough - provider education is also important; (3) insurance coverage and the Individualized Education Program (IEP) assessment can be overwhelming for parents.

A parent member believed that there was a lack of consumer education. Parents need advice in early intervention and/or autism waiver. Parents need to better understand the process. When parents make the initial call to the insurance company they need to ask to speak to a representative who knows about habilitative services coverages. Policy language is difficult to understand. Pediatricians and their medical staff are probably not aware of the responses required for IEPs. Parents also need to tell their employers that they want coverage for all mandates under State law. Self-insured plans are not subject to those mandates.

One of the members suggested that the Workgroup should focus on education and pivotal factors in trying to access service. The member suggested making a list of questions for parents to ask their insurers regarding coverage and then promote this through Med Chi's and other associations' websites and promote other educational tools through other links. The issue is that

consumers don't know if they have coverage for services and don't know how to navigate the systems to get to those services. Available services vary from county to county.

It was decided that the Workgroup needs to develop a guide with questions that parents and pediatricians should ask insurers. All of the government agencies represented could post these questions on their websites. A YouTube video could be very effective. The Department of Health and Mental Hygiene (DHMH) could disseminate the information to all of its partners where parents are likely to access the information. One of the pediatrician members stated that the questions could also be disseminated through State and local educational organizations.

Difference in Access to Services Based on Geography

One of the pediatrician members added that in his practice, he has seen that each county is not created equally especially on the Eastern Shore and Western Maryland where residents are at a disadvantage in accessing habilitative and rehabilitative services.

One member representing DHMH stated that the Workgroup needs to look at access from a geographical perspective. Reimbursement rates are based on geographical areas. A large metropolitan hospital can absorb the low reimbursements for pediatric services. Private practitioners on the Eastern and Western Shore say that they can not accept the low reimbursement rates offered by insurers. Generally speaking, there are more services available under the Infants and Toddlers Program than when a child reaches school age but that also is subject to geographical variation.

Coverage Transitions – Infants and Toddlers, School-Age, Adults

The member from the Maryland State Department of Education (MSDE) stated MSDE hears from many families that if the family has the financial means, it pays for services up front with the hope of obtaining the autism waiver later. It would be interesting to hear from them about how they are meeting gaps in coverage. In addition, it would be helpful to hear from parents about young people exiting the Infants and Toddlers program and moving to the next level of service.

Delegate Kelly pointed out that it has been difficult for the General Assembly to obtain information regarding PT for adults ages 21-26. When looking at the long term costs, more data is needed regarding who falls into the 21-26 age groups for Down syndrome, intellectual disability, etc. When children turn 21, it is important to know what is available and what will expire at age 21.

Some of the members noted that early intervention under the Infants and Toddlers Program is key but as the program was expanded from birth-3 years to birth-5 years, without additional funding, the program does not have enough money to fund all services.

A member suggested that the Developmental Disabilities Administration (DDA) within DHMH be invited to the Workgroup meetings as the DDA may be able to provide another perspective regarding the coordination of coverage for people with developmental disabilities.

Other Workgroup Charges: In order to make the determination for Charge 3, the Workgroup must know what the technical advisory group has recommended regarding the medically necessary and appropriate use of habilitative services to treat autism and autism spectrum disorders. It was decided by the Workgroup that a liaison be established with the technical advisory group.

Commissioner Goldsmith stated that she views the Workgroup's November 1, 2012 report as a progress report rather than a preliminary findings report.

Future Meetings: A survey of the availability of the members for future meetings will be sent to the members.

Adjournment: The meeting was adjourned at 11.00 a.m.

Workgroup on Access to Habilitative Services Benefits

Meeting Minutes

Meeting Date: August 21, 2012

Call to Order: The second meeting of the Workgroup on Access to Habilitative Services Benefits was held in the 24th Floor Hearing Room of the Maryland Insurance Administration, Baltimore, Maryland, on August 21, 2012. Commissioner Goldsmith called the meeting to order at 2:00 p.m.

Members in Attendance:

Debbie Badawi, M.D.	Brenda L. Myrick
Robert A. L. Blake, M.D.	Ginny Paleg
Rachael Faulkner	Deborah Rivkin
Nancy FitzGerald	Steven D. Sorin
Therese M. Goldsmith	Thomas J. Stengel
Delegate Ariana B. Kelly (Co-Chair)	Abila Tazanu-Legall, M.D.
Edward P. Koza, M.D.	Lori Tolen
Bruce Kozlowski	Joseph Vander Walde, M.D.
Rachel London	Bryson Popham for Joseph Winn
John Olderman for Senator Madaleno (Co-Chair)	

Workgroup Members Not in Attendance:

Kimberly A. Bell	Kelli Nelson
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Workgroup Staff in Attendance:

Nancy Egan
Tinna Quigley
Brenda Wilson

Others in Attendance:

Ashlie Bagwell	Linda Stahr
Patrick Carlson	Pam Tenemaza
Robin Elliott	Lanna Warren
Kimberly Robinson	Julie Pitcher Worcester
Patricia Swanson	

Approval of Minutes: The minutes from the June 27, 2012 meeting were introduced. Rachael Faulkner asked that the minutes be amended to add that it was recommended that the Developmental Disabilities Administration (DDA) within DHMH be invited to the Workgroup meetings as the DDA may be able to provide another perspective regarding the coordination of coverage for people with developmental disabilities. The minutes with the amendment were approved by the Workgroup.

Identification of Liaison to Technical Advisory Group: Commissioner Goldsmith stated that Tinna Quigley had volunteered to act as liaison with the technical advisory group and asked if there were any other volunteers. No one else volunteered.

State Ethics Commission Determination and Response: Commissioner Goldsmith informed the Workgroup that the State Ethics Commission had determined that the Workgroup, as an Executive Unit, was subject to the Public Ethics Law, and that its members may be required to file the annual limited board and commission financial disclosure statement. The Commissioner stated that the Workgroup Co-Chairs have submitted a request to the State Ethics Commission, which will consider the request at its next meeting on September 13, 2012.

Discussion of Workgroup Charges One and Two -How to Gather Needed Data:

“The workgroup shall determine:

- 1. whether children who are entitled to and would benefit from habilitative services under health insurance policies or contracts or health maintenance organization contracts are actually receiving them;*
- 2. if the children are not receiving habilitative services, the reasons why”*

General Discussion of Identifying Children not Receiving Access

A member of the Department of Education noted that there is a need to coordinate between services covered under health plans and those under education plans. The bill addresses habilitative services not addressed in the educational plan. The Infant and Toddler Program’s goal is to meet the needs of a child and address the needs of parents in early education. Its focus is more on entering the educational system.

A carrier member understood that the Workgroup’s charge was focused on children (up to the age of 19) who have coverage for habilitative services and to consider what else can be done to access that coverage. The member questioned the need to collect additional data.

It was suggested that insurance companies could compile data based upon the benefits that they have provided for habilitative services. Several members asked against what denominator the data would be compared. There are many children who are uninsured and not included in the Workgroup’s charge.

A pediatrician member said that the children in the Infant and Toddler Program who do not receive adequate services should be identified. Other members agreed that those children should be identified but questioned who is going to identify them and how they can be identified.

One pediatrician member suggested that the workflow of the Infant and Toddler Program be reviewed from a medical perspective. However, there is no clear standard of care in use; it depends upon who identifies the child. Another pediatrician member agreed that a standard of care should be developed.

The Health Care Commission member suggested gathering information from the parental perspective, the clinical perspective and that of the carriers. The Workgroup agreed to divide into four subgroups: Carriers, Providers, Parents, and Educators. At the next meeting, one hour will be designated for small group discussions. Each small group will draft suggested data points, methodologies, and work plan proposed for the full Workgroup's consideration.

Small Group Membership

Group One (Carriers) - Koza, Myrick, Rivkin, Winn

Group Two (Providers) – Bell, Blake, Badawi, Paleg, Tazanu-Legall, Tolen, Vander Walde

Group Three (Parents) - Badawi, Faulkner, Kelly, Nelson, Tazanu-Legall

Group Four (Educators) - FitzGerald, Kozlowski, London, Madaleno, Sorin, Stengel

Discussion of Data Gathering for Group One (Carriers)

One member suggested that the carriers compute the number of children who have received a diagnosis of autism and the reason for that diagnosis. A carrier representative said that coding for autism is poor and that a company would not be able to identify those children who need services and are not receiving those services. The carriers can only provide data for those who have filed claims. Delegate Kelly stated it would be helpful to have data for claims filed and for those denied. In addition, it would be helpful for parents and providers to have the coding used by carriers.

One carrier member stated that at their company, the codes for P.T. or O.T. do not distinguish between rehabilitative services and habilitative services. Another carrier member said that their claim forms do have designated boxes to check for rehabilitative services and habilitative services.

A pediatrician member said that many doctors are not aware of the difference between rehabilitative and habilitative services. Another pediatrician added that doctors try to identify those services that are needed, but that they usually refer a child to a specialist who can identify the correct diagnosis. Many specialists are back logged and a child may not be seen for several months.

It was suggested that information could be gleaned from reviewing the number of claim denials excluding those for durable medical equipment (DME). A carrier member said that many of the claim denials may be for investigational and experimental procedures (I & E). Another carrier member concurred; denials are not helpful because they are usually for I & E such as equine therapy. The coding authorizing coverage occurs at the beginning of the claim process when the decision is made to authorize coverage. If the provider calls for pre-authorization and it is

approved, a carrier cannot deny coverage later. Each carrier has their own procedure for authorization.

The Workgroup established the following topics to be discussed in Group One:

- Diagnoses criteria
- Time frame for data pull
- Claims and denials
- Age ranges such as 0-3, 3-6, 6 and up to age 16
- Hard versus soft data

Discussion of Data Gathering for Group Two (Providers)

One Workgroup member said that the workforce shortage for educational services and health services contributes to the problem. Many OT, PT, and SLP providers are associated with the schools, or in out-of-network private practice. There are many areas in the State in which services are not available.

One therapist said that they must “jump through hoops” to get approval for coverage and that the reimbursement rate is too low. Another member added that specialists can not support themselves on insurance reimbursements.

The Workgroup established the following topics to be discussed in Group Two:

- Survey questions for pediatricians including geographical data
- Survey questions for other clinicians including geographical data
- Other data gathering ideas
- Distribution channels through professional associations

Discussion of Data Gathering for Group Three (Parents)

The Workgroup established the following topics to be discussed in Group Three:

- Use of a recent parent survey by the Office for Genetics as a template for a survey
- Use of focus groups to provide anecdotal information
- Developing questions based on Workgroup Charges One and Two
- Developing questions regarding whether services are being provided through a health plan or an educational plan
- Distribution channels

Discussion of Data Gathering for Group Four (Educators)

A member of the Department of Education reported that 3.8% of the pediatric population is being served by the Infant and Toddler Program, but it is unclear if the children are receiving services beyond the Individualized Family Service Plans. Another member of the Department of

Education said that the only data available involves children who have Individualized Education Programs (IEPs).

A carrier member added that only a small subgroup of the 3.8% will qualify for habilitative services under a health insurance plan because certain conditions cannot be identified at an early age. One pediatrician member added that the school system makes a determination of health services necessary for the child's education but the child may need more services for non-educational outcomes other than those provided. The child's access to services can depend upon the portal through which the child is identified (e.g. educational, medical).

The Department of Education is the State operating agency for the Medicaid Autism waiver. A Department of Education member said that they collect data for educational purposes in age ranges of 0-3, 3-5, 3-21 and 6-21.

The Workgroup established the following topics to be discussed in Group Four:

- Data already on file such as detailed complaint data on IEPs
- Data regarding contract rates to providers
- Geographical differences
- Workflow of the educational plan for early age groups
- Data on denials

Next Meeting: The next meeting will be held on September 5 at 9:00 a. m.

Adjournment: The meeting was adjourned at 4:00 p.m.

Workgroup on Access to Habilitative Services Benefits

Meeting Minutes

Meeting Date: September 5, 2012

Call to Order: The third meeting of the Workgroup on Access to Habilitative Services Benefits was held in the 24th Floor Hearing Room of the Maryland Insurance Administration, Baltimore, Maryland, on September 5, 2012. Delegate Kelly called the meeting to order at 9:00 a.m.

Members in Attendance:

Debbie Badawi, M.D.
Nancy FitzGerald
Therese M. Goldsmith
Delegate Ariana B. Kelly (Co-Chair)
Edward P. Koza, M.D.
Bruce Kozlowski
Senator Richard Madaleno, Jr. (Co-Chair)
Brenda L. Myrick

Ginny Paleg
Les Chalmers for Deborah Rivkin
Steven D. Sorin
Thomas J. Stengel
Abila Tazanu-Legall, M.D.
Lori Tolen
Joseph Vander Walde, M.D.

Workgroup Members Not in Attendance:

Robert A. L. Blake, M.D.
Rachael Faulkner

Rachel London
Kelli Nelson

Workgroup Staff in Attendance:

Nancy Egan
Tinna Quigley
Brenda Wilson

Others in Attendance:

Kimberly Robinson
Sequaya Tasker

Julie Pitcher Worcester

Approval of Minutes: The minutes from the August 21, 2012 meeting were introduced. Amendments were provided by Bruce Kozlowski, Steven D. Sorin, Brenda Myrick, and Abila Tazanu-Legall. The minutes with amendments were approved by the Workgroup.

Development of Questions for Parents and Providers to Ask Insurers When Requesting Coverage for Habilitative Services Benefits: Based on the Workgroup's discussion on August 21, 2012, Commissioner Goldsmith envisioned a template of basic questions for parents to ask their health benefit plan carrier as a starting point. The Workgroup held an open discussion to begin formulating the questions for the template that would be developed into a working draft for the next meeting. One member stated that the initial question a parent should ask should be directed to the employer regarding whether the parent has coverage for habilitative services under the employer's health plan. A carrier member suggested that the parent should start by looking at the benefit documents. Delegate Kelly stated that at a prior meeting it was determined that there is an issue with obtaining information from carriers and the Workgroup should narrow

its focus to questions parents should ask their carriers. A carrier member stated that each carrier is different. The carrier he represents does not use pre-authorization for habilitative services.

A provider member stated that a parent is not worried about insurance in the beginning. Instead, parents are asking for help accessing services. Another parent member suggested working from a broad focus and then defining habilitative services. Delegate Kelly suggested providing hyperlinks along with the questions. A carrier member stated the questions should also address that Maryland residents employed in another state may be covered under a plan not subject to Maryland's habilitative services mandate.

Another member suggested that the questions be geared toward helping parents obtain access to services. Parents should be given options of who to contact to obtain services. Another provider member suggested that the options provide references to obtain additional information. One of the providers noted that some parents do not want information regarding habilitative services included in their child's educational record or medical record. A carrier member stated that generally, there isn't any communication between the carriers and services provided in the educational system. Another provider suggested questions about whether the provider accepts the parents' insurance and detailed questions about coverage and preferred providers.

A discussion ensued about whether coverage/service codes for habilitative services should be provided to parents. Some members thought that parents may need specific coding information. Some carrier members disagreed. They felt that questions for parents should be focused on services needed. In addition, many of the carriers' customer service representatives are not familiar with coding.

Commissioner Goldsmith summarized that the discussion appeared to be focusing on two distinct documents. The Workgroup agreed to focus on two separate documents: one document with questions for parents to ask their carriers, and a second document to serve as a more expansive guide for parents.

Small Groups: The meeting divided into four small groups for discussion about data gathering. Delegate Kelly reminded the small groups to be prepared to discuss their findings at the next meeting.

Next Meeting: The next meeting will be held on September 19, 2012 at 9:00 a.m.

Adjournment: The meeting was adjourned at 11:00 a.m.

Meeting Date: September 19, 2012

Call to Order: The fourth meeting of the Workgroup on Access to Habilitative Services Benefits was held in the 24th Floor Hearing Room of the Maryland Insurance Administration, Baltimore, Maryland, on September 19, 2012. Delegate Kelly called the meeting to order at 9:20 a.m.

Members in Attendance:

Debbie Badawi, M.D.

Rachael Faulkner

Nancy FitzGerald

Therese M. Goldsmith

Delegate Ariana B. Kelly (Co-Chair)

Edward P. Koza, M.D.

Bruce Kozlowski

Rachel London

Senator Richard Madaleno, Jr. (Co-Chair)

Brenda L. Myrick

Ginny Paleg

Deborah Rivkin

Steven D. Sorin

Thomas J. Stengel

Abila Tazanu-Legall, M.D.

Lori Tolen

Joseph Vander Walde , M.D.

Workgroup Members Not in Attendance:

Kimberly A. Bell

Robert A. L. Blake, M.D.

Kelli Nelson

Joe Winn

Workgroup Staff in Attendance:

Nancy Egan

Tinna Quigley

Brenda Wilson

Others in Attendance:

Patricia Swanson

Sequaya Tasker

Lana Warren

John Olderman

Julie Pitcher Worcester

Melissa Evans

Robyn Elliott

Approval of Minutes: The minutes from the September 5, 2012 were distributed for review. The minutes were approved by the Workgroup.

Small Group Reports

Group One-Carriers: The carriers are working on obtaining data based on carrier denials for services. One of the difficulties is that each carrier has different processes in place for claims. In addition, no claim systems have specific codes that are ascribed to habilitative services. One carrier that requires preauthorization of habilitative services can identify the services through the pre-authorization system because the pre-authorization form includes a check-off box for habilitative services. Another carrier does not require pre-authorization of services; the carrier depends on the provider to determine what services are necessary and the parents to understand their benefits.

The carriers agreed that they could provide the following data: number of claims/requests for services; the number of claims paid/approvals provided; and the number of claims denied/pre-authorizations denied. Carriers will pull data for calendar years 2010 and 2011. A separate data pull will be run for fully insured and for administrative service only (ASO) contracts. The data will be broken out for the following age groups:

- 0 up to 3
- 3 up to 6
- 6 up to 11
- 11 up to 18

Reasons for denial by carrier: A question was raised whether the data pull would be able to indicate the reasons why a claim was denied and whether the reason for denial could also show the diagnosis. The carrier members responded that carriers can provide the reasons for denial but the answers will be very general, for example: does not meet criteria or not covered. A member asked if the Maryland Insurance Administration (“MIA”) could pull information from the Appeals and Grievances Unit regarding appeals for denials of coverage for habilitative services. The MIA does not currently distinguish between rehabilitative services and habilitative services when coding the complaints in the Appeals and Grievances Unit. Another member asked if the carriers could pull a small subset of denied claims and provide detailed information on the denials. The carrier members asked that the data pull be implemented in phases. First, pull and review the data and then determine if further information regarding the denials is needed. The carrier members emphasized that they will not be disclosing coding information. The information that they will be providing will be in the aggregate. The Workgroup agreed to the phased approach in pulling the data provided by the carriers. The carriers’ next step will be determining a list of common diagnosis codes to pull. One member shared that the carrier that she represents had researched their large self-funded plans and found that many of them include the benefits for habilitative services.

Group Two-Providers: The provider group is developing two surveys.

Survey 1: The first survey’s target audience is pediatricians, family practitioners, and nurse practitioners. The purpose is to determine if the targeted respondents are referring children with special needs, the criteria they are using for the referrals, and to what programs or services they are referring. One member asked if there were any resources available to determine if the questions being used in the surveys will result in obtaining the data desired. The member volunteered to provide contact information for a statistician and survey expert for the next meeting.

The first draft survey was reviewed by the Workgroup. There was a discussion about the relationship between question 5 and question 9. The questions were designed to determine to whom the provider refers children of different ages. One member stated that question 10 appeared to be a subjective question. The question was to address why services are not being delivered and this question could determine if the recommendations are not followed up. It would be difficult for physicians to respond to this question. One of the members representing the educational system pointed out that sharing the information with the primary care provider may require parental permission. In addition, both question 5 and question 10 should distinguish

between early intervention ages 0-3 and school special education ages 3-21. One member thought the question should ask if the provider confirms insurance coverage. Another added that the question should be more specific about costs such as cost of services. Two suggestions were made for additional questions: Who completes referral forms in your office? Do you participate with insurance?

Survey 2: The second survey being developed is for allied health professionals. The targeted respondents would include physical therapists, occupational therapists, and speech-language pathologists. Additional potential respondents could include nurses, social workers, psychologists, vision specialists and nutritionists. It was suggested that psychologists be included in the first group of targeted respondents. The demographic questions should focus on the practice setting such as the percentage of time divided between early intervention, private practice, hospital (inpatient; outpatient) and special education.

Preliminary ideas about potential areas of additional inquiry were:

- determining whether respondents understand when the State's habilitative services mandate applies (e.g., fully insured vs. self-funded plans);
- determining the source(s) of respondents' referrals.

The workgroup provided some additional areas of inquiry:

- Are you accepting new patients?
- Are you a participating provider?
- If not, do you submit your claim on behalf of parents or do you have parents submit the claim directly to their carrier?

There was general discussion about whether questions on coding should be included in the survey. One of the carrier members stated that she was uncomfortable including any questions about coding. A provider member thought that coding was a barrier for the provider due to ignorance on the part of the provider and the nuances of coding. A carrier member stated that only medical doctors can deny services. The reviewing physician is not just reviewing the coding but the clinical information. The clinical information is reviewed to determine if the service is evidence based, clinically objective and flexible. If the coverage is denied, the patient can appeal through their carrier. If an appeal is sent to the MIA, the medical record is reviewed again by an independent review organization. Carriers provide portals for their participating providers to review the criteria for different services.

Other Discussion: A survey will be sent out about possible meeting dates in December. The Workgroup approved starting the next meeting at 9:30 a.m. Several members asked for some time set aside for small group discussions at the next meeting.

Next Meeting: The next meeting will be held on October 3, 2012 at 9:30 a.m.

Adjournment: The meeting was adjourned at 11:00 a.m.